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Conseil Cri de la santé et des services sociaux de la Baie James
Cree Board of Health and Social Services of James Bay

PATIENT PARTNERSHIP APPROACH TO DIABETES CARE IN EEYOU ISTCHEE: IDENTIFYING BARRIERS AND FACILITATORS

PILOT PROJECT IN MISTISSINI

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INTRODUCTION

The Cree Region of James Bay (Eeyou Istchee):

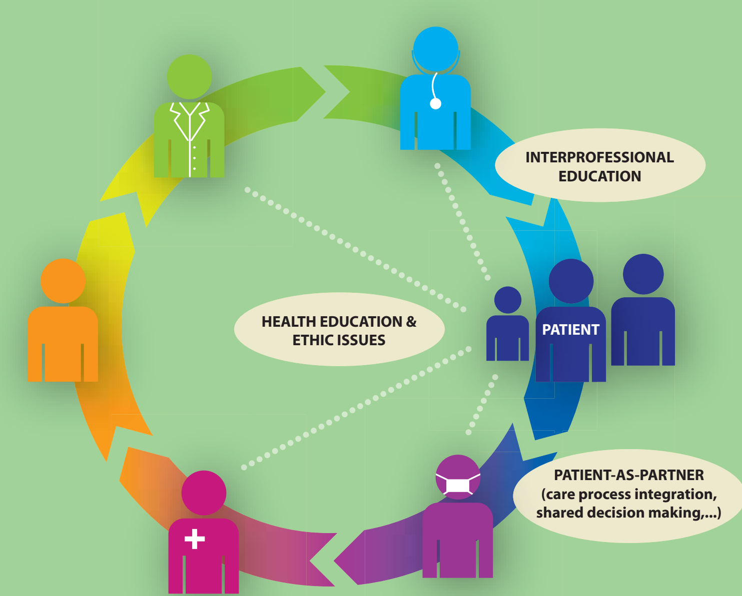
- Region 18 of the Quebec Ministry of Health and Social Services
- Nine remote communities: 4 inland and 5 coastal
- Cree population - approximately 16 000 (2012)[1]
- Mistissini population - 3 864 (2015)[2]

CONTEXT

Cree regional health care is facing many challenges in implementing a patient partnership approach to diabetes care:

- "Epidemic" of diabetes among the Cree population - prevalence of 22% among 20 yrs + (as of December, 2012)[3]
- Geographical isolation
- Lack of Cree health care professionals (HCP)
- Lack of non-aboriginal HCP, with high turnover
- Limited access to specialized services
- Limits of the current organizational structure to fully support patient partnership approach in chronic disease care*

***Patient partnership approach in health care**



OBJECTIVES

1. To identify barriers and facilitators for patient partnership approach to diabetes care, as perceived by Cree patients at the personal, organizational and environmental levels.
2. To contribute in building a regional capacity for developing and carrying out evaluation/needs assessment projects for public health programs and clinical services via ongoing training for local personnel involved in the project.

METHODS/DESIGN

- Project conducted as a pilot in Mistissini to appraise methodology, feasibility and pertinence for quality improvement of regional diabetes care
- Individual face-to-face interviews (average duration 90 min) conducted between June 2013 and December 2014 in Mistissini + demographic and clinical data collected from Cree Diabetes Information System (CDIS)
- Sampling strategy: theoretical sampling approach
- Inclusion criteria: diagnosis of type 2 diabetes, James Bay Cree status, able to fluently speak English, age more than 18 years old, using services from Mistissini clinic
- Data collection tools: semi-structured interview guide with open-ended questions (9 main topics)**
- Data analysis: conventional content analysis

**** Main topics**

1. Personal experience living with diabetes
2. Perception of culturally-adapted services
3. Perceived self-efficacy
4. Communication with HCP
5. Support for diabetes self-management from HCP
6. Continuity of care
7. Role of family in diabetes management
8. Barriers to effective diabetes self-management
9. Missed appointments at Mistissini clinic

Participants

- 9 Cree patients (7 women, 2 men)
- Average age: 40 years
- Average duration of diabetes: 8 years
- Treatment: 5 on insulin, 4 on oral medication

RESULTS

Main identified barriers to a patient partnership approach to diabetes care:

ENVIRONMENTAL LEVEL

Easy access to junk food, high cost of fruit and vegetables at local grocery store, no access to traditional food at grocery store, absence of secure walking trails outside community, limited healthy choices at local restaurants, lack of diabetes management support for people who spend long periods of time in the bush

ORGANIZATIONAL LEVEL

Lack of time and communication to share concerns or discuss questions during clinical visits, lack of support groups and workshops, long waiting time to get follow-up appointments with medical and dental services in the community, limited access to specialized services outside of region, high turnover of HCP, limited appointment/follow-up system at clinic

PERSONAL LEVEL

Difficulties making healthy food choices, lack of nutritious recipes, lack of time and motivation, fears of complications, problem accepting diabetes, challenges of insulin treatment, lack of practical skills, psychological problems, lack of knowledge about medications

RECOMMENDATIONS TO FACILITATE PATIENT PARTNERSHIP APPROACH TO DIABETES CARE

- **Reinforce capacity of HCP to deliver patient partnership and culturally sensitive care** by providing more extensive training on patient partnership approach based on Cree culture and traditions
- **Offer traditional healing practices** at clinic on regular basis
- **Actively involve patients in goal setting and decision making in their own care**, thus recognize patients as equal partners with HCP
- **Systematic screening** for potential distress among patients with multiple co-morbidities
- **Offer diabetes support groups**, especially for newly diagnosed patients, young patients and people who spend a lot of time in the bush
- **Empower patients in transferring their knowledge on diabetes self-management** to other patients/family members by developing Patients as Experts workshops
- **Improve existing appointment/follow-up system** at Mistissini clinic, making it more patient-friendly with a reminder/confirmation system for regular follow-up appointments
- **Involve patients in quality improvement process** by creating a patients' committee at the clinic
- **Reinforce the physical environment in the community** making it more supportive for diabetes self-management
- **Conduct interviews with medical staff** to compare their perceptions and priorities with those of the patients in order to achieve sustainable results

CONCLUSION

In spite of many challenges, there is a good potential that diabetes care in Mistissini can progress to a true patient-HCP partnership. By involving patients in the quality improvement process of health services, we can obtain much better insight into their expectations, needs and priorities regarding the diabetes care they receive. Recognition of patients' expertise and personal experience is a critical element for building a successful patient-HCP partnership approach that empowers not only patients, but also the whole community.

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References

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